Karin Wagner, Certified Rolfer™
2732 SE 18th Ave., Portland, OR 97202
503-230-0087

Health Questionnaire

Name:_____ Date: _____

Address: _____ D.O.B.: _____

_____ Zip:_____ Occupation: _____

Phone: (H)_____(W)_____ Email: _____

(Cell)_____

Have you ever had any of the following conditions or problems? Be descriptive if appropriate.

Heart condition	Y	N	Respiratory problems	Y	N
High/low blood pressure	Y	N	Eliminatory problems	Y	N
Blood clot disorders	Y	N	Circulatory problems	Y	N
Diabetes	Y	N	Digestive problems	Y	N
Cancer	Y	N	Jaw tension or TMJ	Y	N
Thyroid problems	Y	N	Headaches or migraines	Y	N
Osteoporosis	Y	N	Hearing loss	Y	N
Arthritis	Y	N	Sleep trouble	Y	N
HIV/AIDS or Hepatitis	Y	N	Sensitive to: _____		
Pregnant Past/Present/Never			Other: _____		

Are you presently under the care of an MD, naturopath, chiropractor, therapist, or acupuncturist? _____
If yes, for what? _____ Provider's Name _____
What medication have you taken in the past six months? _____
Please describe any past injuries, accidents and surgeries:

_____

_____

_____

List any areas of body discomfort: _____
How do you use your body? Please list current diet, exercise, sports, hobbies or musical instruments.

_____

_____

Have you received, or do you regularly receive some form of massage/bodywork? How often?

_____
Have you ever received Rolfing® before? If so, how many sessions? _____
What would you like to gain from your experience with Rolfing®? _____

_____
Will you seek reimbursement from an auto claim, health insurance, flex plan account, etc? Y/N
How did you hear about me? _____

I certify that the above information is true and accurate to the best of my knowledge.

_____ _____
Client signature (or parent/guardian if under 18 years of age) Date

APPLICATION AND CONSENT FOR ROLFING®

I hereby apply to receive sessions in *Rolfing® Structural Integration* for myself, or for a child for whom I am the legal guardian.

I understand that the purpose of Rolfing® is to balance and align the physical body so that it is supported by gravity in three-dimensional space. This is done through direct manipulation and education so that greater economy and freedom of body movement are achieved.

I understand that Rolfing® is not involved with the treatment of disease of any kind, nor does it substitute for medical diagnosis or treatment when such attention is needed. The Rolfer™ does not treat, prescribe or diagnose an illness, disease, or any other physical or mental disorder of the person. Nothing said or done by a Rolfer™ should be misconstrued to be such.

I understand it is necessary for the Rolfer™ to touch my body in order to assist me in establishing balance and alignment in the body.

I give Karin Wagner, as a Certified Rolfer™, my permission and consent to do all those things necessary in helping me establish balance and alignment, including, but not limited to touching my body. I give the Rolfer full privilege and license to work on my body in such a way as to restore and establish balance and alignment therein.

Furthermore, I understand that any relief of physical or emotional symptoms may or may not occur in conjunction with the organization of the total human being and is not the basic goal of Rolfing®.

I understand that I will be charged for missed sessions with less than 24 hours notice. _____
(initial)

_____ _____
Client Signature (or parent/guardian if under 18 years of age) Date

Permission to share my health information (optional)
I give permission to discuss my health care treatment with my **health providers**, listed on the first page of this form.
For **motor vehicle claims**, I give permission for my chart notes and other health information to be shared as needed.

_____ _____
Client Signature (or parent/guardian if under 18 years of age) Date